DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-468 (Rev. 01/2004)

STATE OF WISCONSIN
SOS Desk (608) 266-9198
Statutory authority: S. 46-985(3)(f) and HSS 65.05(9)
Completion of this form meets the requirements of the State/County contract specified under the Wisconsin Statutes. S. 46.031(2g)

HSRS
FAMILY SUPPORT PROGRAM MODULE

Child and Family Information

Screen 59 New or 84 Update **MODULE TYPE 5**

1 Worker ID	**2** Client ID	**3** MA Number / Social Security Number	
4a Last Name	**4b** First Name	**4c** Middle Name	**4d** Suffix

5 Birthdate (mm/dd/yyyy)	**6** Sex F M	**7a** Hispanic / Latino Y = Yes N = No	**7b** Race (Circle up to 5) A = Asian B = Black or African American P = Native Hawaiian or Pacific Islander I = American Indian or Alaska Native W = White

(Module Key:)

8 Start Date	**9** End Date	**10** Closing Reason	**11** Alternate Care Type (Required if closing reason is 44) 1 Foster care 2 Group home 3 Child caring institution 4 Center developmentally disabled 5 Mental health institute 6 Nursing home

12 Client Characteristics	**13** Diagnosis

14 Assistance Needed for Personal Care
1 Child unable to help him / herself
2 Child needs assistance with some activities
3 Child does not need assistance

15 Limitations in Mobility
1 Child cannot walk
2 Child needs assistance in walking
3 Child does not need assistance in walking

16 Limitations in Verbal Skills
1 Child is nonverbal
2 Child has very limited verbal skills
3 Child is fully verbal

17 Limitations in Cognitive Abilities
1 Child has severe developmental delays
2 Child has moderate / mild developmental delays
3 Child has no cognitive delays

18 Emotional / Behavioral Issues
1 Child presents significant behavioral challenges
2 Child presents minor behavioral challenges
3 Child has no behavioral challenges

19 Medical Needs
1 Apnea monitor
2 Gastrostomy / tube feed
3 Tracheotomy
4 Oxygen dependent
5 Heart monitor
6 Acute psychiatric episode
7 Ongoing medications
8 Degenerative disorder
9 Surgery this year
10 Hospitalization this year

20 Family ID	**21** Number of Caregivers	**22** Adopted Child Yes No	**23** Parent's Special Needs 1 Developmentally disabled 2 AODA 3 Mentally ill 4 Physically disabled 5 Medical condition

24 Income Range
1 0 - 10,000
2 10,001 - 15,000
3 15,001 - 20,000
4 20,001 - 30,000
5 30,001 - 40,000
6 40,001 +

25 Family Cost Share

Screen 79

26 Has child returned from alternate care?
☐ Yes ☐ No If "Yes" enter alternate care type:
1 Foster care
2 Group home
3 Child caring institution
4 Center for developmentally disabled
5 Mental health institute
6 Nursing home

27 Reporting Year Registration 0000	**28** Has family considered out of home placement?		**29** Is family in a crisis situation?	
	Yes	No	Yes	No
	Yes	No	Yes	No
	Yes	No	Yes	No
	Yes	No	Yes	No
	Yes	No	Yes	No
	Yes	No	Yes	No

EXPENDITURES FOR FAMILY SUPPORT SERVICES

Screen 93 (Module Key: _____)

30 Next Review Date

31 Other Programs Used
1 AFDC 3 SSI 5 Katie Beckett
2 BCPN 4 SSI-E 6 Birth to 3

32 Voluntary Resources
1 _____
2 _____

33 Target Group*
* Refer to deskcard

Prog. No.	**34** Subprogram	**35** Estimated Annual Costs	**36** Cost Code A - Add S - Subtract R - Replace	**37** Actual Costs	**38** Delivery (mm) (yyyy)	**39** Service Start Date	**40** Service End Date	**41** Provider Number
	A Architectural modification of home							
	B Child care							
	C Counseling / therapeutic resources							
	D Dental and medical care not otherwise covered							
	E Diagnosis and evaluation - specialized							
	F Diet, nutrition and clothing - specialized							
	G Equipment / supplies - specialized							
	H Homemaker services							
	I In-home nursing services - attendant care							
	J Home training / parent courses							
	K Recreation / alternative activities							
	L Respite care							
	M Transportation							
	N Utility costs - specialized							
	O Vehicle modification							
	P Other, as approved by DHFS							

42 Subprogram P, text:

*** Refer to deskcard**